Primary Care-Based Chronic Disease Self-Management and Quality Improvement (QI) Programs offered through DPHHS

Project	Type	Description	Contact
Cardiovascular Health Program: http://montanacardiovascular.mt.gov			
Blood Pressure Control Kit	Self-Management Toolkit	Kit includes: automated cuff, educational materials, DVD on blood pressure, pedometer, and pill box. CVH program works with clinics to pull data on patients with high BP, who are then sent a kit. Case managers follow up to track outcomes.	Marilyn McLaury, QI Coordinator, Phone: 444-6968 E-mail: MMcLaury@mt.gov
Cholesterol Control Kit	Self-Management Toolkit	Kit Includes: Pedometer, educational materials, "Take Control" lunch bag and water bottle. CVH program works with clinics to pull data on patients with high cholesterol, who are then sent a kit. Case managers follow up to track outcomes.	Marilyn McLaury
Blood Pressure Tacklebox	Provider-Based QI Project	Includes: Provider and patient materials and electronic patient forms, national guidelines, blood pressure management technique information and DVD. Sent to physicians across the state.	Marilyn McLaury
Montana Diabetes Project: http://diabetes.mt.gov			
Diabetes Quality Care Monitoring System (DQCMS)	Provider-Based QI Software	DQCMS is a diabetes registry that can be used by clinics to track key disease/QI indicators (such as HbA1c levels, foot exams, and influenza vaccinations) and then utilize this data to inform QI projects. DQCMS data is submitted quarterly to the Montana Diabetes Project which provides a report back to the clinic on their progress on key indicators. Program includes functionality to track diabetes education.	Chris Jacoby, QI Coordinator, Phone: 444-7324 E-mail: CJacoby@mt.gov
HbA1c Toolkit	Self-Management Toolkit	Kit includes: Patient educational information on healthy eating, staying active and managing medications, as well as a pill box, lunch bag and pedometer. Diabetes Project works with clinics to pull data on patients with an A1c between 7-9% and provide them kits. Pre-post A1cs are tracked before and after the project.	Chris Jacoby
Vaccination Tracking	Patient and Provider QI Project	Diabetes Project works with clinics to provide their patients with vaccination tracking cards for influenza and pneumococcal vaccines. If patients receive vaccines outside of the clinic, the card helps keep track and allows clinics to update their records.	Chris Jacoby
Diabetes and CVD Prevention Program	Self-Management Educational Course	The Diabetes Project funds sites across the state to implement a 10 month group-based course for individuals at risk for diabetes and cardiovascular disease. Primary care providers can refer patients to these courses if they are available in their community.	Diane Arave, DPP Coordinator, Phone: 444-0593 E-mail: darave2@mt.gov

Montana Asthma Control Program: http://dphhs.mt.gov/asthma			
Asthma Care Monitoring System (ACMS)	Provider-based QI Software	ACMS is an asthma registry that can be used by clinics to track key disease/QI indicators (such as level of asthma control, peak flow values, referrals and influenza vaccinations) and then utilize this data to inform QI projects. ACMS data is submitted quarterly to the Montana Asthma Control Program which provides a report back to the clinic on their progress related to key indicators. ACMS clinics agree to implement 1 QI project a year based on the indicator data they receive from the system.	Jeanne Cannon, QI Coordinator Phone: 444-4593 E-mail: jcannon@mt.gov
Asthma Demonstration Device Toolkits	Provider-based QI Kit	Includes: Hard plastic case filled with demonstration inhalers, spacers and peak flow meters as well as a bronchiole model and patient education materials. Provided to clinics across Montana to use for asthma education.	Jeanne Cannon
Other QI projects promoted by the Chronic Disease Bureau in DPHHS focus on increasing tobacco cessation referrals and improving rates of cancer screenings such as Fecal Occult Blood Tests. We have not included descriptions of these projects as they are more related to chronic disease prevention than chronic disease self management. If you are interested in any of these projects, contact Todd Harwell at 444-1437.			